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11-14-2020

Workplace Bullying in Healthcare: A Qualitative Analysis of Bystander Experiences

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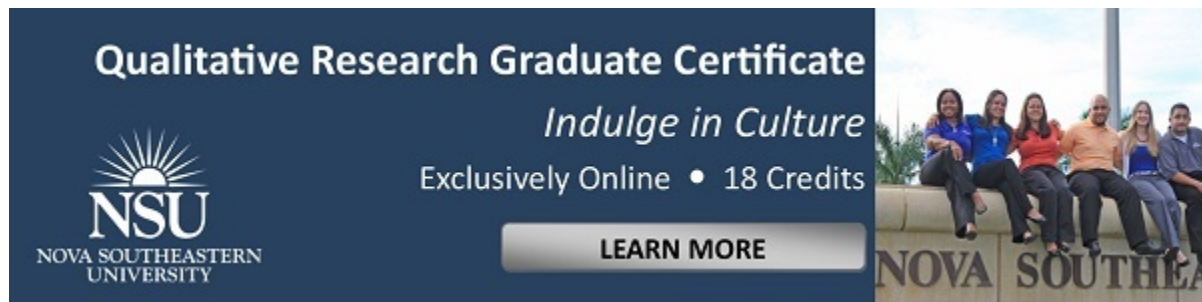
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Recommended APA Citation

Thompson, N. J., Carter, M., Crampton, P., Burford, B., Illing, J., & Morrow, G. (2020). Workplace Bullying in Healthcare: A Qualitative Analysis of Bystander Experiences. *The Qualitative Report*, 25(11), 3993-4028. Retrieved from <https://nsuworks.nova.edu/tqr/vol25/iss11/12>

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Workplace Bullying in Healthcare: A Qualitative Analysis of Bystander Experiences

Abstract

Bystander action has been proposed as a promising intervention to tackle workplace bullying, however there is a lack of in-depth qualitative research on the direct experiences of bystanders. In this paper, we developed a more comprehensive definition of bullying bystanders, and examined first person accounts from healthcare professionals who had been bystanders to workplace bullying. These perspectives highlighted factors that influence the type and the extent of support bystanders may offer to targets. Semi-structured telephone interviews were conducted with 43 healthcare professionals who were working in the UK, of which 24 had directly witnessed bullying. The data were transcribed and analysed using Thematic Analysis. The analysis identified four themes that describe factors that influence the type and extent of support bystanders offer to targets of bullying: (a) the negative impact of witnessing bullying on bystanders, (b) perceptions of target responsibility, (c) fear of repercussions, and (d) bystander awareness. Our findings illustrate that, within the healthcare setting, bystanders face multiple barriers to offering support to targets and these factors need to be considered in the wider context of implementing bystander interventions in healthcare settings.

Keywords

Bystander, Workplace Bullying, Employee Support, Managers, Qualitative Methods, Healthcare, Thematic Analysis, Human Factors

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Acknowledgements

We are grateful to Charlotte Rothwell for contributing to the design of the study. This project was funded by the North East Strategic Health Authority and the Northern Deanery in the UK. The funding organisations had no role in the study design or analysis of raw data.

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Workplace Bullying in Healthcare: A Qualitative Analysis of Bystander Experiences

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Introduction

Over the course of their life, a person has a notable chance that they will be exposed to some degree of bullying, whether this is at school, during adolescence, in sport, or in the workplace (Monks & Coyne, 2011). Public awareness of bullying has been heightened more recently through the recognition of cyber-bullying in schools and the workplace (Farley et al., 2018) and high profile movements to challenge inappropriate harassment and mistreatment at work such as #MeToo (Manikonda et al., 2018). Despite attempts by organisations to address bullying, the use of existing approaches has not resulted in a sustained reduction. Bullying can be described as

harassing, offending, socially excluding someone or negatively affecting someone's work tasks...it has to occur repeatedly and regularly...and over a period of time. Bullying is an escalating process in the course of which the

person confronted ends up in an inferior position and becomes the target of systematic negative social acts. (Einarsen et al., 2003, p. 15)

These “negative social acts” can incorporate work-related bullying, person-related bullying, and physical intimidation. Inherent in this definition is the presentation of bullying as a power imbalanced dyad between perpetrator and target. However, acts of workplace bullying are often witnessed by employees who are not directly involved as either target or perpetrator. A large proportion of employees witness colleagues being bullied, with frequencies ranging from 35% to 80% (Lutgen-Sandvik, 2006; Ortega et al., 2009). This has prompted a number of researchers to suggest the merits of bystander action in tackling bullying (Illing et al., 2013; Lansbury, 2014; Pouwelse et al., 2018). Consideration of the bystander as a key element of the bullying episode and a possible vehicle for intervention remains an important area of investigation. However, qualitative research drawing upon first person bystander accounts is to date under-represented. This paper will first outline the context of workplace bullying in a healthcare workplace setting. A broader definition of bystanders to bullying will then be introduced and previous literature on the bystander role, the reasons identified for a lack of bystander intervention, and factors that affect the appraisal of witnessed negative behaviours will be discussed.

Workplace bullying is a persistent problem in the UK National Health Service (Carter et al., 2013; Hoel & Cooper, 2000; Quine, 1999). This problem is a concern for healthcare workforces across the world as similar prevalence levels have been reported internationally (Cooper-Thomas et al., 2013; Illing et al., 2016; Loerbroks et al., 2015; Spector et al., 2014). Consistently, evidence has demonstrated that bullying in healthcare is associated with diminished organisational performance and negative effects on individual employee wellbeing (Johnson, 2009; Loerbroks et al., 2015). Within the UK healthcare sector, a number of inquiries into poor patient care have shared a common characteristic—that the management cultures themselves permitted, and were often the source of, bullying across the workforce (Francis, 2013; Kennedy, 2013).

A growing body of evidence suggests that bullying may increase the risk of errors, leading to poorer levels of patient care and safety (Lallukka et al., 2011; Paice & Smith, 2009; Roche et al., 2010). Bullying can function as a disruptive behaviour that erodes team working and the ability to develop a safety culture (Wahr et al., 2013). Workplace incivility and rudeness, which are regarded as lower intensity negative behaviours compared to bullying (Herscovis, 2011), have also been shown to have a detrimental effect on performance and patient care, notably increasing the perceived risk to patients (Bradley et al., 2015; Laschinger, 2014; Porath & Erez, 2007; Porath & Erez, 2009; Riskin et al., 2015). In a study examining nurses, 85% reported that around 10% or more of colleagues were disrespectful to the extent that this undermined their ability to share concerns or speak up about problems and only 24% actually confronted these colleagues and shared their concerns (Maxfield et al., 2011). Studies have also shown that bullying resulted in the stifling of discussion and help-seeking behaviours that ultimately could have consequences for patient safety (Carter et al., 2013). This is supported by other research in which impaired individual performance, team functioning, and broader communication have been shown to heighten the risk of healthcare errors (Lingard et al., 2004; Richter et al., 2011). Collectively, this evidence indicates that the presence of workplace bullying within the healthcare context poses a significant risk to patient outcomes if left unmanaged.

In response, organisations have implemented a range of interventions, such as training, workplace policies, mediation, and counselling (Caponecchia et al., 2020). In a review of approaches available to healthcare organisations, bystander action has been identified as a promising intervention (Illing et al., 2013); this is further supported in the healthcare context

with the endorsement of strategies to speak up when critical incidents and errors are witnessed (Okuyama et al., 2014). Currently, there are few studies that directly report on the experiences of bullying bystanders (for example, D'Cruz & Noronha, 2011; Wu & Wu, 2019). This article attempts to develop our understanding of the contextualised experiences of the bystander role. To do so, however, we must identify who qualifies as a "bystander."

The commonly used definitions for bystanders, applied to workplace bullying, are often limited in their scope. For example, D'Cruz and Noronha (2011) defined bystanders as "those individuals who are present during the bullying incident(s) at the workplace" (p. 269). This definition includes employees who are not in the bullying dyad, their involvement being a consequence of observing the act of bullying. This limits the bystander role to simply a proximal witness of events. Lansbury (2014) has suggested that any person present should be classed as a bystander, prompting more recent research to adopt a broader, inclusive understanding of what constitutes a bystander (Pouwelse et al., 2018). However, bystanders can become involved in acts of mistreatment in other ways, often via indirect and vicarious experiencing of the event (Skarlicki & Kulik, 2004). For example, a bystander could be made aware of an incident immediately after a bullying episode through interaction with the perpetrator or target, without directly witnessing the event themselves (Coyne et al., 2004; Namie, 2000). They may take on the role of listening to the target's account of the event, offering sympathy and validation (Bloch, 2012).

Targets may informally turn to colleagues for support, which can be distinguished from the formal roles of colleague support in organisations (Eaton & Sanders, 2012) such as confidential counsellors and listening schemes, which offer organised informal or peer support (Hubert, 2012). However both informal and formal roles, through their involvement with the target, fulfil the bystander position. Social proximity to the target or the perpetrator may also lead to an individual becoming a bystander, through their connection as work colleagues, family members or friends, for example. Where negative work relationships escalate, it is difficult for bystanders to remain uninvolved as the targets will tend to seek support for their case (Volkema et al., 1996). Consequently, bystanders who are not directly involved can contribute to the sense-making process of targets (Samnani, 2013). Existing typologies of bullying bystander roles describe behaviours that vary in the level of participation (from active to avoidant) and in the extent that they support the perpetrator or target (Paull et al., 2012; Twemlow et al., 2004). The differing bystander roles and associated behaviour in existing typologies can be categorised in relation to their level of involvement in the bullying episode – for example, ignoring or avoiding the bullying episode, in contrast to speaking out or supporting the target. The roles can also be categorised in relation to whether the bystander's actions can be viewed as identifying with the target or the perpetrator and consequently whether these acts are constructive or destructive (Paull et al., 2012). In sum, the extent of a bystander's involvement can be extremely varied, from being a direct witness of the behaviours to acting as a confidant who is removed from the actual event.

To reflect this much broader bystander role, we utilised an expanded definition to that previously offered. In this study we define a bystander as an individual who witnesses a bullying event and/or its aftermath, or who is in a position to potentially provide third-party support to either the perpetrator or target.

The reaction of bystanders can be difficult to predict and this unpredictability can be compounded as their involvement may fluctuate over time. Where an existing closeness is established, and the target is viewed as a friend rather than just a work colleague, a bystander will be more likely to act in defence of the target (Coyne et al., 2019). However, where such a strong relationship does not exist, bystanders may decide to avoid getting involved in the situation and such inaction risks being viewed as condoning or supporting the bullying (Lewis & Orford, 2005). In some instances, the bystander may even collude in the bullying (Einarsen

et al., 1994; Paull et al., 2012). Bystanders can assign blame either to the target or the perpetrator, and this may result in support for the target or social exclusion (Ng et al., 2019; Bloch, 2012). Bystander reactions can be moderated by the work itself: when bullying constitutes work-related behaviours (e.g., setting unreasonable targets and deadlines; Einarsen et al., 2003), bystanders are less likely to support the target and more likely to agree with the actions of the perpetrator (Coyne et al., 2019). Targets of bullying have frequently reported the absence of support from colleagues (Hoel & Einarsen, 2003). This often generates a secondary effect of the bullying whereby targets experience feelings of isolation from the organisation and from colleagues (Tye-Williams & Krone, 2015).

There are many reasons why bystanders might choose not to intervene in workplace bullying or why responses may vary over time. Bystanders are often aware of their own vulnerability and can be fearful of retribution from the perpetrator or the risk of becoming targets themselves (Rayner, 1999b; Rayner et al., 2003). Thus, initial support provided by a bystander may over time be limited or withdrawn as a consequence of concern over repercussions (D'Cruz & Noronha, 2011; Matthiesen et al., 2003). Further explanations have suggested that bystanders do not intervene because they do not know how to help the target (van Heugten, 2011). This may lead to the bystander being frustrated over their inability to intervene, and display anger directed at the organisation for not controlling the perpetrator (Keashley & Jagatic, 2003), or they may experience guilt and distress over not being able to support the target (Tehrani, 2004). Bystanders often prefer to discuss the event with colleagues as a low-involvement reaction (MacCurtain et al., 2018; Rayner, 1999b). Furthermore, Catley et al. (2017) described the reluctance of witnesses to be involved in formal procedures. Other studies have suggested that some bystanders may deny they have any responsibility to intervene (Mulder et al., 2014; Mulder et al., 2015) or see a bullying situation as fair treatment of a difficult or problematic colleague (Leymann, 1990; Ng et al., 2019), in which case they may not feel compelled to intervene. The severity of the behavioural display may also be an important influence on responses. Reich and Hershcovis (2015) found that in instances of incivility, bystanders displayed negativity toward perpetrators, but this did not lead to positive action, concluding that incivility itself may not be sufficient to prompt an intervention.

The “bystander effect” may offer another explanation. A series of experiments investigating the conditions under which participants intervene with a stranger in danger identified that bystanders must assess three factors: whether they perceive the event as an emergency situation, whether they feel personally responsible for dealing with it, and whether they possess the skills and resources to act (Latane & Darley 1968; Latane & Darley 1969; Latane & Nida, 1981). Lansbury (2014), however, suggests a number of limitations in applying the bystander effect studies to workplace bullying. Notably, bystanders in the workplace are not likely to be strangers, bullying is typically not viewed as an emergency situation, and bullying always involves a perpetrator. A primary step proposed in bystander effect studies was that the participant needed to notice the event (Latane & Nida, 1981), however with workplace bullying the bystander may not recognise the behaviour being displayed by the perpetrator as bullying or label it as such until it has escalated (Escartin et al., 2009). Bystanders may also not recognise the severity of an incident (Tracy et al., 2006) and may be less likely to intervene if a situation is seen as ambiguous (Solomon et al., 1978). The bullying perpetrator and target typically share a past, and it is often difficult for a bystander to fully make sense of the observed behaviour, having no knowledge of what preceded it (Einarsen et al., 2003; Hoel et al., 1999). It is also important to note that bystanders may only observe an isolated event, whereas the target experiences the behaviour as part of a series of systematic negative acts (Hoel & Einarsen, 2003).

Targets themselves often report difficulty in recognising their experience as “bullying” (Hoel & Beale, 2006), making it even more challenging for bystanders to do so (Parzefall &

Salin, 2010). Hoel and Cooper (2000) found 47% of employees had witnessed some form of bullying over the previous five years, suggesting that not all employees are exposed as observers. This difficulty in judging whether an employee is being bullied or not can be exacerbated when management, who are the source of a large proportion of bullying behaviour (Carter et al., 2013; Rayner et al., 1999), are being observed. Managerial styles can vary greatly, with laissez-faire to autocratic leadership styles being associated with different degrees of overt behaviour (Hoel et al., 2010), some of which could be viewed simply as legitimate managerial practice. Subtle bullying behaviours can also be blended with legitimate organisational drivers for meeting targets (Parzefall & Salin, 2010), with some bullying behaviours becoming rationalised or normal in organisational settings (Heames & Harvey, 2006). Within the healthcare context, work-related behaviours, for example being assigned an unmanageable workload or someone withholding information that affects an individual's performance, have been found to be common (Carter et al., 2013). Consequently, limited observations of ambiguous behaviour, which could be subtle bullying but could also be legitimate work activity by the manager, may be less likely to be interpreted as behaviour warranting support from the bystander.

When bystanders do witness colleagues experiencing bullying behaviours, a consistent finding is that this is associated with immediate negative outcomes for the bystanders themselves including higher levels of psychological distress such as anxiety and stress (Carter et al., 2013; Hoel & Cooper, 2000; Vartia, 2001), heightened levels of intention to quit (Rayner, 1999a), and lower job satisfaction (Einarsen et al., 2003). This can be further sustained if a bystander was required to act as a witness during a formal investigative process or hearing (Merchant & Hoel, 2003), however where an employee is restrained from speaking out this has also been shown to be associated with psychological and physical harm (Cortina & Magley, 2003). Evidence on the longer-term impact is limited. Although some studies have indicated the effects can manifest into experiences of depression (e.g., Emdad et al., 2013; Vartia, 2001), these effects have been also attributed to the bystander's own experiences of personal bullying (Nielsen & Einarsen, 2013).

Taken together, the evidence highlights the negative impact on bystanders. However, bystander support can offer significant benefits to targets. When targets receive support from colleagues, they report lower levels of depression, stress and burnout, and higher levels of job satisfaction in comparison to unsupported colleagues (Quine, 1999). However, the social support that bystanders provide can vary in type and its extent (Paull et al., 2012; Twemlow et al., 2004). In wellbeing research, social support has been shown to reduce stress in the target (Danna & Griffin, 1999), reduce health problems and reinforce the ability to cope (Cohen & Syme, 1985; Dormann & Zapf, 1999). The person offering support can play a decisive role in determining how the target manages to cope with a difficult situation; through the manner in which the target is approached and treated, and by the advice that he or she is given (Leymann & Gustafsson, 1996). The function of social support can be quite varied. House (1981) proposed four different forms which have relevance for the bullying bystander role: evaluative support, emotional support, informative support, and instrumental support. Evaluative support involves the provision of realistic feedback to the target. This may act as a form of sense-making (Lutgen-Sandvik, 2008; Volkema et al., 1996). For example, a target turning to a co-worker to help them understand or validate whether the behaviour they experienced was bullying (D'Cruz & Noronha, 2011; Thompson & Catley, 2018). Bystanders can offer emotional support, which refers to the provision of care and attention, as well as informative support, which refers to the provision of information about rights and means of dealing with the conflict. Finally, instrumental support incorporates the provision of direct help and support for targets; a few studies have reported instances where bystanders have stood up to the perpetrator and defended the target successfully (Leck & Galperin, 2006; Lutgen-Sandvik,

2006). Similarly, in the healthcare context, interventions such as engaging in “crucial conversations” (Grenny, 2009; Maxfield et al., 2011) have been adopted as a form of instrumental support to address issues with employee silence and not speaking up when observing potential concerns.

The most appropriate type of support is determined by the target’s needs at that time (Cutrona & Russell, 1990). Support will have a limited effect if these needs are not taken into account or if there is incongruence between the support required and the support offered. For example, a target may be seeking appropriate advice from colleagues regarding what they really think he or she should do, but they may receive sympathy instead, which they may regard as less helpful (Matthiesen et al., 2003).

In summary, a growing body of evidence has identified the key role of bystanders in bullying episodes. Despite the high prevalence of witnessed bullying, many targets report an absence of support. In particular in the healthcare setting, there is a high level of unwillingness to speak out over concerns. Evidence suggests that there are many barriers to bystander intervention, including concern over retribution and becoming a target themselves, uncertainty about how to intervene, and ambiguity in appraisal of the witnessed behaviours. However, given the benefits of bystander support, developing an intervention for bystanders appears to be a promising avenue for further study. If successful, this could have the potential to reduce the detrimental effects of bullying on targets as well as on patient care.

Rationale for the study

The prevalence of bystander exposure to bullying, and the associated negative outcomes of such experiences have, with few exceptions, been studied through cross-sectional survey methods and experimental designs (Niven et al., 2020). Consequently, the current understanding of the bystander experience remains epistemologically very narrow. To date, the use of quantitative, experimental, and cross-sectional studies has shaped our understanding of how bystanders react to bullying (Niven et al., 2020). Previous study findings reinforce the need for an in-depth understanding of the experiences of bystanders of bullying (D’Cruz & Noronha, 2011; van Heugten, 2010; van Heugten, 2011). However, there remains a lack of qualitative studies that provide contextualised accounts of actual experiences, and in particular, research findings that demonstrate which bystander support is of most use for targets (Pouwelse et al., 2018). This has prompted van Heugten (2010) to suggest that “to achieve higher levels of social support and lower the threshold of tolerance for incivility, understanding of the bystander phenomenon as it relates to workplace bullying requires further attention” (p. 652).

The present study addresses this research gap by investigating factors that shape the experiences of bystanders and the support they offer targets within the healthcare workplace setting. Firstly, we explored the different types of support that bystanders offer. Secondly, we examined the barriers and enablers which may influence the type of support provision. Accordingly, the paper seeks to answer the following research questions:

RQ1: What kind of support, if any, do bystanders offer?

RQ2: What determines bystander support to targets of workplace bullying?

A qualitative approach was adopted as it has been shown to offer rich descriptive details of events and hostile relationships (Glomb, 2002). An inductive thematic analysis (Braun & Clarke, 2006) was selected to achieve the study aim. Following our reading of previous qualitative studies in workplace bullying research, a number of alternative analytic approaches were considered. For example, Interpretive Phenomenological Analysis (Smith, Flowers & Larkin, 2013), as used by D’Cruz and Noronha (2018); discourse analysis (Johnson, 2015) and

narrative analysis (Tye-Williams & Krone, 2015) have provided excellent, in-depth insights, occasionally on individual participants. However, our intention was to examine patterns across the data at the semantic level, whereby the themes presented are reported as the explicit, or surface meaning of the data, and not underlying latent constructs (Braun & Clarke, 2006). Therefore, alternative analytic approaches were rejected as we wanted to produce findings which were not wed to pre-existing theoretical frameworks. A critical concern for us was to present findings that were accessible to healthcare practitioners, as part of our ongoing applied research in healthcare settings, and therefore we wanted to use an analytic framework that did not require any pre-existing detailed theoretical or technical knowledge.

An epistemological position of critical realism (Bhaskar, 2010), positioned between positivism and constructionism, was adopted to acknowledge how individuals make meaning of their experience, and that this is shaped by the broader social context (Abubaker & Bagley, 2016; Liefoghe & Olafsson, 1999). Therefore, research findings are presented within the given context while offering the potential for some wider generalisation of experience (Wahyuni, 2012). Consequently, the findings reported here are on the experience of being a bullying bystander in the specific context of the UK healthcare sector, which offers potential generalisability of experience to other healthcare settings and the wider workplace.

Telephone interviews were used as they provide a rich insight into the area of interest and offer an efficient method to conduct data collection over a geographically dispersed sample (Shuy, 2002). Furthermore, this method of data collection was regarded as particularly effective for studying sensitive topics, such as bullying, as participants can feel they have greater control over the interaction, and perceive a higher level of anonymity and distance from the interviewer, which can ease any discomfort or awkwardness (Oltmann, 2016).

Interviews took place across a mixture of participant settings including being at home and in a quiet space in the workplace, which offered a degree of flexibility for the interviewee (Holt, 2010). However, researchers were mindful that interviews may be emotionally challenging for the participant and ensured that they had guidance available to signpost participants to support, should they need it. Furthermore, the use of telephone interviews provided a methodological approach that was mindful of recommendations for conducting sensitive qualitative research in workplace bullying (Fahie, 2014). The emotional challenges of discussing potentially quite traumatic events and looking ahead in anticipating potential problems within the interview were considered as part of the risk assessment process. Consequently, where possible, interviews were scheduled for when the researcher was not working on their own. This ensured that if required the researcher was able to seek support from the broader research project team while interviews were taking place or could discuss afterwards if they felt that the interview had included difficult content or was emotionally taxing.

Method

Participants

Employees working across seven UK National Health Service organisations responded to a workplace bullying questionnaire (n=2950) as part of the first phase of a research study. The questionnaire was anonymous, and participants were assured that their individual responses would remain confidential (see Carter et al., 2013, for more details on this first phase). The questionnaire included an invitation to a further stage of research, the current paper, where they could participate in a follow-up telephone interview. Follow-up respondents (n=164) were sent a screening questionnaire; this included items on occupational group, length of service, age, and whether they classified their bullying experience as being accused of

bullying, a witness, or a target. A purposive sample was drawn from the employees who returned the screening questionnaire (n=112). To be considered for inclusion in the sample, potential participants had to report experience of being a target or witness of bullying, or of being accused of bullying. The sampling strategy also aimed to represent all seven NHS organisations. Participants (n=43) were then approached through their preferred means of contact and interviews were conducted at a subsequent time, convenient for the participant. The intention of the recruitment strategy was to recruit individuals who were targets, perpetrators/accused and bystanders from a broad range of occupational groups so that we could identify consistent themes across the sample as well as then attempt to examine distinctiveness between the groups. Our recruitment was able to achieve sufficient participants to identify consistency of themes. However, we were not able to recruit sufficient participants across all occupational groups. In practice, this was due to participant availability and the finite time allocated for this phase in the research project. Some of the demands of working in the healthcare setting, such as rostering patterns or coping with staffing changes and shortages, restricted the participants' availability and in some instances resulted in repeated rescheduling of interviews. Some participants who completed the screening survey did not respond to follow-up contacts and, for ethical purposes, we took a position of only sending one invitation and two follow ups, at which stage we presumed they had changed their mind. A further complication was that participants identified themselves in multiple roles, for example as a bystander and target, due to multiple experiences. During the interview, participants further elaborated on bullying experiences, which also affected how we classified them; for example, three participants described roles as investigators or having general awareness of bullying, which did not fully fit into any of the three roles. Consequently, recruiting specific numbers of participants to each group proved difficult within the scope of the study.

Within the sample, over half of the participants interviewed had witnessed workplace bullying (n=24). The data presented here are first person accounts, drawn from the interviews in which participants described their experiences of being a bystander to bullying. Of those participants, many also had experience as a target of bullying (n=16). Table 1 describes the demographic characteristics of the participants, indicating that they were predominantly female, represented all age groups, and incorporated most major occupational groups in the acute healthcare workplace setting.

Table 1
Demographic details of the participants

	Freq	Percentage
Occupational group	43	
Nurses	9	20.9
Midwives	2	4.7
Medical/Dental	8	18.6
Allied Health Professionals	6	14.0
Healthcare Scientists/Technicians	1	2.3
Wider Healthcare Team (e.g., admin, central/corporate services, maintenance, facilities)	9	20.9
General Management	4	9.3
Did not disclose	4	9.3
Gender	43	
Male	8	18.6
Female	35	81.4

Age	43	
25-34	3	7.0
35-44	7	16.3
45-54	20	46.5
55+	8	18.6
Did not disclose	5	11.6
Self-identified bullying roles		
Target only	16	37.2
Witness only	8	18.6
Target + witness	11	25.6
Target + witness + accused	5	11.6
Other (e.g., investigation role or broad awareness of bullying in their organisation)	3	7.0

Note: Some participants did not disclose all demographic information. Five participants did not provide their age. Participants also would often identify with multiple bullying roles due to having had more than one experience of bullying.

Materials: Semi-structured interview

The interviewers used a pre-devised script for structuring the interviews. A degree of flexibility was incorporated into this design whereby the questions could be re-phrased or reformulated and interviewers could also seek to employ effective verbal cues to aid interviewee response. For example, in the course of answering a question a participant may have partially or fully moved on to answering a subsequent question on the script. Rather than repeat the verbatim question from the interview script, the interviewer would rephrase the question to integrate it into the natural flow of the conversation. Care was taken to retain the purpose of the question and this approach was aimed at elaborating on the answers provided rather than skipping an already asked question. Often, when working through the script, it was acknowledged that the question might have already been answered but participants were invited to add to or elaborate on their earlier response.

The interview schedule was developed by expanding on the research aims, the findings from survey data during the earlier phase of the study (Carter et al., 2013), and from within the existing literature. Interview questions covered participants' narrative accounts of any bullying experience(s), accusations of being a bully, bystander and witness accounts, organisational factors, support and recommendations. The interview questions were divided into different sections:

- Demographic, job and background information, followed by the question: "Can you tell me whether you have experienced bullying yourself, witnessed it, or been accused of being a bully?" The participant's response to this question directed the interviewer to use an appropriate interview schedule, as variations on the questions had been produced for use with participants who reported being accused, a target, a bystander, or a target and bystander of bullying.
- Questions about the episodes and behaviours participants had experienced or witnessed and any actions that were taken following the events.

- Questions about the organisational setting and the participant's views on how bullying was managed.

The full interview schedule is available as an Appendix to this paper.

Procedure

Semi-structured interviews were conducted by telephone. The interviews were conducted by three researchers (NJT, PEC, MC). Each interview lasted up to 50 minutes (mean=27.2 minutes) with shorter interviews typically reflecting a participant describing a specific event being witnessed in comparison to longer interviews where a participant might describe multiple events or experiences. All participants provided informed consent to take part in the interviews and agreed to audio recording and verbatim transcription. None of the researchers experienced technical problems that could have impacted data collection. Occasionally there was content that was not sufficiently audible to fully transcribe, however these instances were extremely rare. Furthermore, despite previous suggestions of a risk that telephone interviews could lead to the loss or distortion of data (Garbett & McCormack, 2001; Nunkoosing, 2005), none of the researchers reported that they felt this was the case. On the contrary, the researchers felt that the greater anonymity enabled a degree of intimacy, which lends support to other studies that challenge early assumptions on the limitations of telephone interviews as a method (Irvine et al., 2013; Novick, 2008).

The study design and procedures were reviewed and approved by County Durham & Tees Valley 2 NHS Research Ethics Committee (REC Ref No: 09/H0908/46).

Data Analysis

The interview data were analysed in accordance with the principles of Inductive Thematic Analysis (Braun & Clarke, 2006) at a semantic level. The initial phase of analysis involved examining eight of the interview transcripts. These were selected on the basis of being the lengthier transcripts, therefore offering potentially the most data, and also including interviews from all of the interviewers. Eight interviews provided sufficient data to see the broad scope of the data and for three of the researchers (NJT, PEC, MC) to discuss this in relation to coding and themes. Pragmatically, the in-depth discussion of coding across any more than eight interviews was not possible within the timeframe of the project. However, these steps did provide us with an in-depth scrutiny of our coding which was then applied across the remaining transcripts. During this phase we used line-by-line coding (initial interpretations of data), focused coding (frequent occurrences across the transcripts), and the recognition of patterns to form an initial set of prominent themes. An initial thematic map was produced to display these key themes in relation to both research questions. Further verification was sought from other members of the research team who had not been involved in conducting the interviews or data analysis (JI, GM, BB). These individuals reviewed the coding of the themes and content coded within each theme against sample transcripts. The review of analysis adopted a critical friend approach whereby researchers meet and give voice to their interpretation while others listen. Those listening then provide critical feedback that encourages reflection and the exploration of other interpretation and explanations (Cowan & Taylor, 2016; Smith & McGannon, 2018). The interpretation and consideration behind coding was presented by the three authors conducting the analysis (NJT, MC, PEC) and critical feedback was then provided by the other members of the group (JI, GM, BB). Agreement of the framework was reached at this stage and the remaining interviews were then analysed against the framework. Following this, any disagreements were resolved through discussion (between NJT, MC and

PEC) and realignment of the codes to the themes extracted, resulting in consensus being gained from all the interviewers and the independent reviewers throughout the analytic process. A thematic map was produced and refined throughout the process to aid understanding of the inter-relationship of themes and thematic development. The production of each thematic map provided an analytic trail as we were able to track how themes evolved or amalgamated with others and where they originated from in the transcript coding. As a research team we were therefore able to review the development of themes by revisiting each thematic map iteration or reviewing the early stages of the coding.

The analytic process was managed through NVivo version 10 (Castleberry, 2014). The current study was part of a larger project that included a quantitative survey to examine the prevalence and outcomes of bullying. This data, which mainly focused on the target, has been reported elsewhere (Carter et al., 2013). Findings reported here focus on the qualitative data on bystander experiences.

Results

The first research question, “What kind of support, if any, do bystanders provide?” was answered through identifying the different types of support that the bystanders offered. In relation to the second research question, “What determines bystander support to targets of workplace bullying?” four themes were identified: the negative impact of witnessing bullying on bystanders, perceptions of target responsibility, fear of repercussions, and bystander awareness. At times, there were aspects of the participants’ responses that overlapped across themes. However, this can reflect understanding in reality which is often made up of isolated concepts and experiences that are relative to each other. These themes are summarised in Table 2. The data extracts presented below are the best representational examples drawn from within the theme and from across the whole data set of bystander reports.

Table 2
Summary of themes, definitions, and data extracts

Theme (Research Question)	Definition	Example data extract
The support, if any, that bystanders offer targets (RQ1)	The extent of the support that bystanders offer targets	When I see my colleagues doing it to their trainees I am extremely uncomfortable and I do make, have on occasion made comments to them in private about their behaviour
Perceptions of target responsibility (RQ2)	How the perception of the target’s responsibility to act influenced the support provided by the bystanders	I think as the victim of bullying, you are the only one in a position to stop it and I do get frustrated sometimes and upset with him that he doesn't take it further
Fear of repercussions as a constraint to offering support. (RQ2)	How the perception that providing support will bring about repercussions on the bystander presents a barrier to then providing support to the target	They were afraid that the same would happen to them
Bystander awareness of	The extent that the bystanders were aware of	I've seen junior people, I don't know if the terms always bullied but treated

bullying events (RQ2)	bullying events taking place and the behaviours that were witnessed	badly and the impact of that if you do it several times, I can only imagine that they feel bullied
The negative impact of witnessing bullying on bystanders (RQ2)	The impact that witnessing bullying had on the bystanders and how this effected support provision	I'm standing here thinking I find your behaviour offensive, never mind the poor individual who is actually being bullied

What kind of support, if any, do bystanders provide?

This theme is defined as the scope of the support that bystanders offered to targets, which included the type and extent of support offered. Participants expressed a desire or intention to help, which is not surprising in the healthcare setting. None of the participants indicated that they tried to ignore bullying situations where they might witness bullying or acted in collusion with the perpetrator. Participants disclosed that they offered support which could be considered as serving different functions to the target. In the following extract, the participant is relatively assertive in recommending that the target report the bullying:

Well if I see it happening I always go and say to the person “look you need to go and report this, you cannot let them speak to you like that, you cannot let them push you.” Because that’s like a form of bullying, it’s verbal bullying and I said it has a mental effect on people. I always tell them to go and report it but whether they do or not, I don’t know. (Nurse)

Through this intervention, participants in the bystander role offer support that confirms to the target that their experience was out of the ordinary, the bystander had witnessed the event, and also that they regarded it as inappropriate behaviour. This direct action would also have demonstrated the act of support to the target. However, such interventions were referred to less frequently than other forms of support. The direct nature of the support in this extract “I always tell them to go and report it” may also illustrate the possibility that some intended support could risk placing pressure on the target to act when they are not ready or prepared to do so. More often, participants described their support as being constrained:

I mean obviously I felt for her, I tried to give her as much support as I could, but in some respects I sort of felt powerless really to sort of help her because I wasn’t involved in the situation. (Nurse)

I mean I was mortified by what I was seeing and I thought well if I try and stop him, it might [help]. If I can try and interrupt him, [and] say ‘I don’t think this is good what you are doing!’. I mean I wasn’t on a higher level so I wasn’t in a position to address it in that way, but I just felt if I could try and interrupt it. But it wouldn’t stop. (Mental Health Nurse)

The people that are getting bullied, you’ve got to feel for them, all you can do is try and support the bullied person and just advise them what to do. Because they don’t want to report it, all you can do is support people and hope things improve. (Admin/Clerical)

In the extracts above, participants display empathy towards the target and express a feeling that they had provided as much support as they could. In the first extract, this is explained as a feeling that despite being a bystander, they are not involved with the situation. Traditionally in bullying research, there is a view of bullying as a straightforward dyad and consequently a bystander may feel that they should not get involved. In the second extract, a similar view of not getting involved is presented, however the explanation is broader in that the participant is not in a position to do so, due to the seniority of the perpetrator. In the third extract, the unwillingness of the target to report the bullying is recognised as limiting the support offered. This demonstrates that the extent of support provided can vary depending on whether the bystander witnessed the event, whether the target is willing to report the bullying, and whether the bystander believes they are in a position to act. A recurring feature of these extracts is the lack of confidence that the bystanders have in their own intervention being effective. The participants describe feelings of powerlessness to bring about change, compounded by concern for repercussions, and a sense of pessimism that all they can do is try and support the target and hope they might then report the bullying.

Participants reported certain types of support, such as where the bystander might act on the target's behalf, less frequently. Only one participant reported an example when, as a bystander, they directly intervened on the target's behalf by approaching the perpetrator's line manager and witnesses:

Well I try to speak to the people that's witnessed it and say, "If you're not happy with how you're being treated, you need to take it further." But they won't, they honestly won't take it further. Or I mention it to the manager in between her that talking to people like that is not appropriate. But I don't think she has much power over her really either. (Nurse)

In the extract above, the bystander does take it upon themselves to act on behalf of the target by approaching the target's manager. However, evident here are other confounding factors, such as the lack of action from the target and that directly intervening in lieu of the target's own action may not guarantee an effective intervention, or may even make the situation worse for the target. These extracts demonstrate that support from bystanders is varied; some types of support seem more commonly offered than others, particularly where the intervention is directed towards the target and not the bully. The decision to intervene, or not, is a conscious one that considers a range of factors; not least the perceived appropriateness, confidence of success and the position of the bystander and those involved.

What determines bystander support?

Bystander awareness of bullying events

This theme is defined as the extent to which the bystanders were aware of bullying events taking place and the behaviours that were witnessed. Participants were aware of a colleague experiencing bullying either through direct observation of behaviour or through disclosure from the target after the event. In recalling bullying episodes, participants often described bullying more generally, rather than focusing on specific episodes. These examples were mainly overt displays of bullying, although there were not any patterns identified to indicate that bystanders observed overt displays more frequently than covert or more subtle displays of undermining. Furthermore, participants regarded the experiences they described as actual bullying events but did not specifically refer to particular types of negative behaviours

(e.g., task-related bullying or socially isolating behaviours). None of the participants reported denying that the bullying had occurred or that they questioned the validity of the claim:

I've witnessed people [being bullied], lots of tears, people just behaving badly with other people and not considering other people's feelings, picking on somebody when they have got a weakness [...] using quite manipulative behaviour to try and undermine you. (Allied Health Professional)

If you're just a bystander, sometimes talking to the person who is being bullied to say "I saw that, can I help you?...Is that typical?...Are you alright?" But also... "would you like me to help with this?" Because that may not be the first time [they have been bullied]... and also sometimes if you are actually there ... you know what's going on, [and ask] "do you need help?" It is very hard to challenge. (Medical Consultant)

In the above extracts, the bystander becomes involved in the overall bullying experience, and take some form of role, as a support to the target or through being a witness to the event. The role of the bystander is not seen as a neutral position. For example, in the second extract the participant describes a number of potential actions that might be initiated, such as talking to the target, reassuring them, offering support, validating their experience and offering proactive assistance. Therefore, it is worth considering the facets of support that bystanders offer in more detail. Throughout the interviews, participants provided examples of where they have been both willing and unwilling to support the target. These will be examined in turn.

The negative impact of witnessing bullying on bystanders

This theme is defined as the negative impact that witnessing bullying had on the bystanders, including the emotional impact as well as a reluctance to communicate openly and report errors in the future. Participants who witnessed bullying frequently described the emotional impact it caused by using terms such as "frustration," "anger," "being uncomfortable," "feeling absolutely dreadful," "offensive," "threatened," and "vulnerable." In addition to the impact on the individual, team supportiveness was affected; specifically, when these events took place, it created uncomfortable environments. A consequence of this was that offering support became difficult, as communication became stifled and individual survival concerns superseded concerns for supporting the targeted team members:

I know that both the nursing staff and myself feel extremely uncomfortable. We know that if a particular trainee were going to work with this consultant, we're all thinking, "Oh *#!' Is it going to be us next?" (Medical Consultant)

You are certainly less trusting and less likely to go to the manager in question with a problem. If you do make a genuine technical mistake, we work in a technical environment, I mean we always try not to make mistakes, if you did you kind of have to take it to him with great caution. (Admin/Clerical)

The extracts also reinforce the multi-level effects of bullying within the workplace. In the healthcare context, the impact on communication, attention, trust, and confidence in raising concerns are critical in relation to effective team functioning and subsequent performance and patient safety. Furthermore, in workplace settings where such negative conditions persist, it is also unlikely that some types of bystander support provision would occur. This would be

particularly the case for instrumental support, where a bystander might stand up to a perpetrator and defend a target, as the bystanders themselves may be also experiencing a notable emotional impact from witnessing the bullying which could deter them from directly intervening.

Perceptions of target responsibility

This theme is defined as how the perception of the target's responsibility to act influenced the support provided by the bystander. Some participants reported that one barrier to the degree of support offered was the sense that it was the responsibility of the target, rather than the bystander, to act. Support offered by participants was limited to emotional support, the provision of information and guidance, and the validation of the target's experiences. Most forms of support reported by participants were directed at the target. The absence of examples of frequent interventions on behalf of the target, such as the bystander formally reporting the bullying themselves, reinforces the sense that often the bystander did not want to get involved. There was a sense that the target had a responsibility to take action themselves:

I wouldn't like to do that on his behalf because I would feel I would be overstepping my mark as a colleague really. Obviously if he was a very close friend or a member of my family, then I would protect him in whatever way I could. But as he's just a colleague, I can only offer advice and support if needed.
(Admin/Clerical)

If something happened to somebody and I could see they were visibly upset, I would perhaps try approach them and see if they wanted me to act on their behalf but at the same time I believe we are all adults, and so people don't want to take it any further. And you know, it's not for me to take that decision for them, but if something happened to me and it was obviously upsetting me then I would definitely go further. (Midwife)

The first extract illustrated that the bystander is consciously marking the limit of their responsibility with an unwillingness to act on the behalf of the target but a willingness to offer support within particular parameters. A conscious decision-making process that rationalises what support bystanders feel comfortable with providing is evident in these instances, although it is unclear whether these represent rationalisations that were made at the time or through retrospective reflection. Despite visual evidence indicating that a target was affected by an incident and "visibly upset," this would not be sufficient to prompt direct intervention toward the perpetrator.

The presence of an existing relationship with the target is presented as a mediating factor, suggesting that more support might be offered if the target was a relative or close friend. In the second extract, the participant states that they would offer to act on the target's behalf but acknowledges that the decision to intervene would remain with the target and this is still positioned within their responsibility. The participant compares their own hypothetical response to bullying to the target's actual response to bullying. Consequently, a factor that influences the scope of the support seems to be the bystander's own appraisal, specifically comparing how they might act against how the target does act, and the extent to which they believe the target should take responsibility for acting.

Fear of repercussions as a constraint to offering support

This theme is defined as the provision or withholding of support based on bystander perceptions that providing support to the target will bring about repercussions for themselves. A consistent pattern in the data was participants reporting their concern for possible repercussions as a barrier to their involvement as a bystander, including offering support to the target, as evident in the extract below. The participants stated that they might become a target of bullying in retaliation for speaking out against the perpetrator or accusing them of bullying behaviours:

You feel absolutely dreadful for the person who is going through it. But it takes a lot of guts to say something because you know you are going to get hurled at as well. (Healthcare Management)

Career limiting, because I think if I'd said anything, well it would have had serious consequences for me. (Nurse)

Although participants did not describe ignoring or dismissing the relevance of the bullying that they witnessed, they did often describe using avoidant behavioural approaches, motivated by a fear of repercussions, where bystanders attempt to distance themselves from the bullying behaviour. Possible repercussions were primarily related to becoming a target themselves. Secondary concerns included being perceived negatively across the organisation, being excessively monitored, and the potential for detrimental implications for their career. A factor that contributes to this is the lack of awareness of the support that the organisation offers. More broadly, bystander responses are also mediated by the openness of the wider organisational culture. Some participants referred to the organisation's bullying culture, which may also constrain bystander support.

Participants reported not always providing support to the targets. For example, one explanation for why support might not be offered in the above extract was a view that, by offering active bystander support, they may become stigmatised. A concern raised was that in supporting the target the bystander then may be criticised by the rest of the team:

I've had to support colleagues who have [been bullied]. But I've tried not to guide them or make suggestions because I don't want to be branded a trouble maker. (Allied Health Professional)

In the above extract, the participant suggests that there is an expectation of only providing a certain type of support, however the bystander is concerned that they do not offer what might be deemed too much guidance, as this might lead to being "branded as a trouble maker."

The findings can be thematically classified as the experiences and impact of being a bystander, the nature of the support, concern over repercussions, and a judgement on the target's own responsibility. The findings show that bystanders can take different support roles in the bullying, directly as a witness or someone who becomes involved after the event, therefore bystander definitions do need to reflect this. The involvement as a bystander is not without an emotional impact with participants reporting a range of negative emotional experiences. Participants reported different degrees of support which fulfilled a range of bystander functions including offering emotional support, providing information and guidance, and validation. Direct interventions were less commonly reported. The provision of support was not automatic or guaranteed and bystanders described the appropriateness of getting

involved, concern of potential repercussions, and their perception of the responsibility of the target to act as factors that were influential in the decision.

Discussion

This study aimed to understand the role of the bystander in relation to the provision of support to targets of bullying in a healthcare setting, and the factors that may influence these decisions. Semi-structured interviews were conducted with 43 employees from a range of healthcare occupational groups, of which 24 reported bystander experiences. The study represents an emergent focus in workplace bullying research on using the “bystander lens” rather than the traditional voice of the target (D'Cruz & Noronha, 2011; van Heugten, 2011).

The act of raising a concern to an employer about potential bullying is the cornerstone of most strategies designed to manage workplace bullying (Thompson & Catley, 2018). In our study over half of the participants witnessed bullying and were therefore in a position to report a concern. However, in most cases incidents were not reported to the organisation. This finding confirms a pattern found elsewhere that bullying bystanders are typically reluctant to report incidents to the organisation (Catley et al., 2017; Rayner, 1999b).

The adoption of a broader bystander definition in this study goes beyond earlier studies that have adopted less inclusive bystander definitions (e.g., Lansbury, 2014; Pouwelse et al., 2018). This new definition encompasses a greater range of situations where bystanders may be in a position where they could offer support without directly witnessing the bullying episode itself. This follows more recent adoptions of definitions that seek greater specificity on the role of the bystander in the workplace context and the support that can be offered (Niven et al., 2020; Pouwelse et al., 2018). Being a witness does imply a range of responses that could result in supporting or not supporting the target (Paull et al., 2012). In utilising this expanded definition, we consider a more comprehensive range of potential bystander support. Our definition removes the requirement of the bystander to be in “immediate proximity” to the bullying event as a crucial characteristic. The new definition allows the inclusion of the co-worker or friend/family member as a bystander, as someone who the target might turn to for support or help in interpreting an event in its aftermath.

Across the experiences discussed in the interviews, the descriptions used did not consistently focus on particular patterns of behaviour over others. Therefore, no further insight is provided into previous assertions that bystanders might be more aware of certain behaviours over and above others (Escartin et al., 2009; Glaso et al., 2007). Within the current study the bullying events witnessed were confirmed in the eyes of the participants as actual bullying. Therefore, any lack of support can be viewed as a consequence of the decision by the bystander not to intervene, rather than as a result of the bystanders not observing particular bullying behaviour patterns. However, it should be noted that the receptiveness of the immediate team or organisational culture was not measured, and these factors may have influenced bystander decisions. The work environment has been shown to be highly influential (Einarsen et al., 1994) and is likely to influence the extent that a bystander would be willing to challenge, support or report a witnessed act of bullying.

The importance of the bystander role was highlighted in these findings which, combined with the high bystander prevalence levels previously reported (Carter et al., 2013; Hoel & Cooper, 2000; Lovell & Lee, 2011; Quine, 1999, 2001, 2002; Steadman et al., 2009), continue to emphasise the need for the bystander to be a major focus, rather than a secondary consideration of future bullying research, as there is much still to be understood. The bystander here is described not simply as a passive witness, but active in playing a role that can influence the consequences of events following bullying incidents (Paull et al., 2012). More research is required into the extent that these roles and reactions overlap, as well as the degree of

discreteness they possess or whether they act as series of escalating steps that lead to different levels of target support. Furthermore, the influence of the organisational culture and the acceptability of raising concerns on bystander responses warrants further investigation.

The current study findings confirm that bystanders can play an active role in bullying events and that bystanders experience negative emotional effects, such as confusion, guilt, and fear, which have consequences for their own wellbeing (Nielsen & Einarsen, 2013; Vartia, 2001). The lack of direct action reported by bystanders in our findings, alongside the negative toll the experience places on the bystander, may somewhat challenge earlier assertions (e.g., Illing et al., 2013; Lansbury, 2014) that have proposed the importance of bystander interventions. Our findings describe the role of the bystander within the healthcare context. In doing so we highlight the potentially restricted scope that experimental designs can offer where they strip away organisational context. The organisational context should not be ignored, as the bystander role cannot be fully examined in isolation. Instead, analytic approaches should be adopted that can provide a fuller understanding of the prevailing organisational context that will ultimately shape any bystander decisions and action.

Our findings confirm that bystander intervention cannot be assumed or left to individual responsibility, but need to be integrated with contextualised organisation strategies that enable and support bystander action. Critically important for future research is the need to understand the factors that prompt bystanders to act in the face of bullying episodes, for example through learning from reports of successful interventions, and identifying broader interventions that help to remove barriers and support bystanders to intervene, whilst minimising the negative impact.

The negative consequences of the bullying event were shown to expand beyond the individual level. A further effect demonstrated at the group level was the creation of uncomfortable environments that lacked supportiveness and stifled communication (Carter et al., 2013; Hoel & Cooper, 2000; Vartia, 2001). These behaviours have also been found to be detrimental to team performance in healthcare settings (Bradley et al., 2015; Laschinger, 2014; Porath & Erez, 2007, 2009; Riskin et al., 2015). The impact of bullying on patient care has been suggested previously (Lallukka et al., 2011; Paice & Smith, 2009; Roche et al., 2010). Although these findings do not offer causal evidence, they nevertheless provide further support to the growing pattern of findings that indicate that there are secondary effects of bullying on the working environment at the team level which generate risks for patient care. In high stakes environments, such as healthcare and safety critical industries which rely on effective team working and communication (Catchpole et al., 2007), the ramifications of bullying described here, at the team level, illustrate a significant hazard. This may have provided the conditions that allowed or even encouraged bullying (Einarsen et al., 2017), and has the potential to escalate and introduce heightened risks for safety and patient care.

Participants expressed a desire to support targets, reflecting earlier findings (Hoel & Einarsen, 2003; Rayner, 1999b). A range of support was offered, in line with the frameworks proposed elsewhere (House, 1981; Leymann & Gustafsson, 1996; Twemlow et al., 2004). None of the participants reported colluding with the bullying perpetrator as has been suggested elsewhere (Namie & Lutgen-Sandvik, 2010; Paull et al., 2012; Tye-Williams & Krone, 2015). As the frequency of collusion has been shown to be very low in comparison to other bystander reactions (Rayner, 1999b), a lack of evidence in the current study may reflect this and consequently to understand collusion further, a larger sample of bystanders may be required to offer insight from this potential sub-group.

Bystander support did vary according to House's (1981) classification; emotional, evaluative, and informative styles of support were most frequently reported, while on only a few occasions did participants refer to using instrumental support strategies, which confirms previous findings (Leck & Galperin 2006; Lutgen-Sandvik, 2008). The support provision

described went beyond simply intervening in the moment of directly witnessing events, which is how the bystander has been positioned in the past. Instead, bystanders were often involved in the aftermath, further reinforcing the sense-making role that they undertake (Lutgen-Sandvik, 2008; Volkema et al., 1996). A methodological implication of this finding is that it reinforces the need to utilise broader definitions that encompass the more expansive role of bystanders. Whilst demonstrating the range of support bystanders can offer, these findings do not suggest that one particular style is preferable over another. Target-focused support was more commonly reported, which may suggest this style may be more preferential or easier to provide. The use of different styles of support does present a potential risk where particular situations may suit one style, but the bystander adopts another, or where the bystander support offered is incongruent with what is desired by the target. For example, a target may feel supported by a strong advocate stepping forward in support of them, while other targets may feel pushed aside, undermined, or even intimidated by the bystander's strong advocacy. A challenge in practice, and for future research that examines bystander support, is that the target's perception of their support needs to determine what is appropriate support and what is not.

A notable theme in the literature is the perceived absence of support reported by targets (Matthiesen et al., 2003; Rayner, 1999b; Vartia, 2001). Our participants in one sense confirmed this through reported inaction, which was related to among other factors, a fear of repercussion. However, participants, as a marked contradiction to earlier studies, frequently described how they supported targets and none openly described ignoring or avoiding the support of targets. There are a number of possible explanations proposed for this difference in findings. The perceived absence of support behaviour could simply reflect an incongruence between the support required by the target and the level of support offered by the bystander. A related factor reported was that participants attributed the responsibility to address the situation to the target and not to the bystander, which may also shape the extent of the support they are willing to offer. Consequently, targets may not receive the support they require and may not feel adequately supported, while bystanders may feel that they have provided sufficient support and that further action is the target's responsibility.

Existing relationships were also reported to be a determining factor in support offered, with a greater likelihood of support to those with a positive pre-existing relationship with the bystander (Coyne et al., 2004; Coyne et al., 2019). However, previous studies have also described the withdrawal of support during the course of the bullying experiences (D'Cruz & Noronha, 2011; Matthiesen et al., 2003), therefore, a perceived lack of support may also reflect sympathy fatigue (Bloch, 2012) as an initially supportive bystander withdraws their involvement.

A prominent theme was the bystander's concern regarding possible repercussions arising as a result of supporting the target. This confirms earlier research findings that have highlighted organisational barriers to reporting bullying concerns, including the fear of repercussions (Carter et al., 2013; Rayner, 1999b). The lack of longitudinal data analysis in the current study prevented detailed exploration of the impact of concern for repercussions on long term bystander involvement and ongoing support provision, however other studies have shown it to diminish over time (e.g., D'Cruz & Noronha, 2011). The theme of fear of repercussions may also provide a further explanation for the perceived lack of support often reported by targets. In the longer term, these concerns may result in the diminishing level of bystander support due to the fear of being targeted themselves or becoming isolated from the group.

Our study findings present notable methodological implications as they reinforce the dynamic nature of bystander support (Bloch, 2012; D'Cruz & Noronha, 2011). In examining the context that the bystander behaviour inhabits, in this case of a healthcare workplace setting, the potential for important new insights materialise.

Future designs that are unable to reflect the fluidity of bystander involvement or capture the important contextual factors that contribute to bystander action may only offer a partial insight into the phenomenon. Therefore, longitudinal research designs, or data collection across multiple time points may be necessary in order to examine the changing, temporal and responsive nature of bystander support. Qualitative designs that can document contextual real world factors, particularly when focused on specific sectors, settings or occupational groups did provide rich insights consistent with previous adoptions of this approach.

Finally, the current context of the healthcare setting raises particular concerns regarding the impact on patient care. The degrading of communication and trust, the presence of fear of the repercussions for speaking up and supporting colleagues are all symptomatic of how extensive bullying can ripple beyond the target and throughout the team (Coyne et al., 2000). In doing so, bullying causes further negative outcomes in degrading the actual mechanisms which might act to reduce its occurrence in the workplace, such as colleague support and intervention.

Limitations of the study

The data from the sample provided insight into the key themes relevant to bystander support provision and it was felt that data saturation was achieved and key themes were captured across a range of occupational groups within the healthcare sector. However, the study is limited in that it would have been advantageous to have explored further variations within different occupational groups to determine whether these themes were consistently reported within a given profession. Further research should examine variations of bystander support that are particular to different professions and the extent they are generalizable across the broader healthcare sector. In addition, some themes present in the literature (e.g., the presence of collusion) did not materialise in our study which might suggest this is not as prominent an issue as feared. A number of other explanations are available; it could be that our sample group of bystanders was not large enough for a sub-group of those who have taken part in collusion to be present, those accused of bullying are often reluctant to identify themselves as a bully so may simply have not disclosed this in their interviews, or indeed healthcare might be a sector where collusion is simply less prevalent than other work contexts. Consequently, a larger purposive sample of bystanders is required with a focus on collusion, in order to identify those who might have experienced this and to address some of these outstanding concerns.

A number of methodological limitations were evident in the study, which present further implications for the use of semi-structured interviews when examining bullying targets, perpetrators and bystanders. A tautological issue arises where interviews attempt to examine the presence and experience of bullying as there is a reliance on the participants acknowledging or identifying experiences as bullying. It has previously been acknowledged that participants might not associate particular bullying behaviours or their own experiences as bullying. Consequently, the use of semi-structured interviews in bullying research may be methodologically problematic as it unintentionally may canonise the participant's population and range of behaviours to those collectively recognised as bullying. Furthermore, an observation from the study was that despite being asked to provide specific concrete examples, participants would often slip into providing abstract or generalised responses to how they behaved during events. Where specific reactions were described participants were able to provide a rationale for why they may have behaved in a particular way. However, within the interview method it was not possible to clarify if this was a conscious decision at the time or in retrospect where the participant has had time to reflect on the events.

These methodological concerns are problematic as they risk diluting specificity of the recall of the events and the details of particularly negative behaviour displays are lost.

Consequently, the research focus might drift into the bystanders describing how the bystander thinks or hopes they might react, or how they generally react, rather than recalling how they actually did react. An important methodological point here is that managing this relies on the skill of the interviewer to use follow up questions or re-orientate generalised responses to allow the focus on particular events. The oscillation between specific and generalised recall may affect the accuracy of understanding the actual events. This reinforces a need for research to use interviewing methods that focus on being able to draw upon specific timelines, such as critical incident techniques (e.g., Lewis et al., 2010), visual timelines (e.g., Mazzetti & Blenkinsopp, 2012), or alternative qualitative methods such as the use of ethnographic approaches, naturalistic data collection, documentary analysis or case study designs which may suffer less from recall problems but may also provide greater insight into the bystander role in relation to specific bullying episodes.

Finally, the focus on participant actions is quite limited without a broader systemic consideration of the workplace culture and the immediate environment in which the bullying events take place. Where we are trying to develop a context rich understanding of how bullying materialises and the actions that are taken by individual bystanders in response, it is essential as part of this picture that we also include data collection factors at the team, environment and cultural level as these may act as confounding variables in any intervention process which relies on an employee to speak up and raise a concern.

Conclusion

This study presents a more comprehensive definition of bystanders to bullying. Critically, the current study is set in a particular occupational context, therefore, it offers insights that are grounded in the experiences of being a bystander to bullying within the healthcare setting. The study discusses the negative impact on bystanders and considers a number of factors that act as barriers to intervening, notably the perceived responsibility of the target to act and the fear of repercussions should the bystander act.

A further critical factor is the perceived organisational culture and the extent of openness that empowers employees to speak out. Where there is a general lack of understanding as to the extent that the organisation might support the bystander action, or ostracise the individual as some form of "trouble maker," then this would likely result in the organisational culture significantly inhibiting the efficacy of any bystander intervention efforts. Consequently, there is much to be done at an organisational level to ensure bystanders can be empowered to intervene without fear of repercussions. Furthermore, while we recognise bystander support can be beneficial when directed at both target and perpetrator, this should not replace the organisation's responsibility to act. Future research, grounded in the practice context, can offer important insights into enablers and barriers to bystander activity, in particular how the social construction of bullying at the organisational level may shape this. Such critical insights would offer real possibilities for creating research informed strategies that reduce the occurrences of workplace bullying in healthcare settings.

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Appendix 1: Interview schedule

Workplace Bullying: Interview guide for telephone interviews

Introduction

Be prepared to signpost participant to relevant help services (occupational health, HR, counselling) if required.

Hello, my name is _____ and I'm calling from the [Research Team], please could I speak to _____?

[If not there, leave message with name, [Our organisation] and phone no., don't mention bullying study]

[To participant]

Hello, am I speaking to _____?

I'm _____, a researcher at the [Research Team]. You kindly agreed to participate in a telephone interview. The interview should take between 30 and 45 minutes. Is now a good time?

- We're working on a project looking at bullying in the NHS. We're an independent research group and we're hoping to get a better understanding of people's experiences relating to bullying. In particular, we are really interested in hearing how it was handled by the Trust, and what support was, or would have been, helpful.
- I would also like to let you know that we are not able to take cases forward on your behalf, but we can signpost you to help in your Trust.
- Thank you for sending in a consent form. I'd just like to remind you that you can choose to stop this interview at any time or skip certain questions, and what you say will be kept strictly confidential, unless you tell me about very serious misconduct presenting significant risk to your safety or patient safety.
- When we report results, there will be no way to identify you.

[If any queries on consent form, ask them here]

If you are happy for me to do so, I'll be recording this interview. This is just so that we can transcribe it later, to make sure I don't miss anything. The tapes are kept completely confidential and are only shared in the research team. We remove any identifying information and keep them in a locked filing cabinet. If we use any information, it is also anonymised.

Are you happy for me to record the interview?

If YES: Thanks, I'll start recording. This is interview _____.

****Key Questions that should be asked if short on time*

Questions

If no screening questionnaire (or incomplete), complete one:

- Could you tell me how long you've worked for the NHS please?
- ...And could I ask what your job is? I have a list of workgroups – do you belong to [*refer to screening tool*]
- Which Trust do you work for?
- Could you tell me which age group you belong to please? [*list from screening tool*]

- Before we begin, can you tell me whether you have experienced bullying yourself, witnessed it, or been accused of being a bully?

If completed screening tool:

I see from the questionnaire you filled in that you have....

- Experienced bullying yourself...
- Been accused of bullying...
- Witnessed bullying...

If bullied (or bullied + witnessed bullying)...

1. Could you tell me what types of bullying behaviours you experienced (or saw)? (see NAQ if need some examples)
 2. How often did you experience (or see) this?
 3. Do you think their behaviour was intentional?
 4. What was your relationship with the person who bullied you? Were they your manager / employee / co-worker?
- Do you have a previous relationship?

***5. How did you (and if witnessed, the target of the bullying) respond?

***6. Did you report the bullying?

If YES:

- Who to?
- What was their reaction?

***6a. What actions did **they** / the **organisation** take?

- Could you tell me about the **process**?
- How did you **feel** going through the process?
- What was the **outcome**?
- How did you **feel** about the outcome? Was it the outcome you were hoping for?
- What **improvements** would you make?
- Was there anything you found particularly **helpful**?
- Was the **support** you received effective?
- What do you think should have been done **differently**?
- Were you **offered help** such as: mediation, coaching, team building, training, contacts

in HR or occupational health?

If NO:

- Did you consider **reporting** it? [*get at process in deciding not to report*]
- Were there **reasons** why you didn't report it?
- What do you feel are the **barriers** to reporting bullying?
- Would there have been/be something that would help you feel able to report it?
- What sort of help and **support** would you like / have liked?

7. Is the behaviour still continuing?

If yes: Would you like me to tell you about support services in your Trust?

If no: Is there a reason why it stopped?

8. What is the situation like now?

- Is the bully still working for the Trust? Are they working with you?
- What is your relationship with them like now? Has it changed?

***9. What has been the effect of this on you?

- For example, did you consider leaving the organisation or changing jobs?
- If clinical role: how you dealt with patients / colleagues?
- Work (productivity, concentration, professional reputation/status)
- Confidence
- Health
- Relationships and home life, work-life balance
- Sickness rates
- Stress

***10. How do you feel the **Trust** deals with bullying generally?

- Is the approach effective and fair to all employees?
- Is there enough support in place?

***11. Do you have any **suggestions** as to how Trusts could improve how they manage workplace bullying?

12. Are you aware of the Trust's bullying **policy**?

13. Do you know where to look to find the policy?

14. Do you know what **support** is available and how to access it?

15. Did you get support or advice from elsewhere (outside the Trust)?

[GO TO CLOSE OF INTERVIEW OR ADDITIONAL QUESTIONS IF TIME REMAINING]

If accused of being a bully...

1. What was your **relationship** with the person who accused you of bullying? Were they your manager / employee / co-worker?

- Do you have a previous relationship?

2. How did you **feel** about it when you were told?

3. Was it mentioned informally first?

***4. What types of **behaviours** were you accused of?

- Would you classify those behaviours as bullying?

***5. How did you **respond/react**?

- Discussions with individual?
- Discussions with manager/peers?
- Contact with HR?
- Contact with unions?
- Did you change your behaviour (towards that individual, and/or others)?

***6. What **actions** did the individual / organisation take?

- Was the action taken **formal or informal** (or both)?
- Could you tell me about the **process**?
- How did you **feel** going through the process?
- What was the **outcome**? [was anyone relocated? redeployed? disciplined?]
- How did you **feel** about the outcome?
- Were you offered any help or **support**? What support were you offered?
- Was the support you received **effective**?
- Was there anything you found particularly **helpful or unhelpful**?
- What do you think should have been done **differently**? What **improvements** would you make?

7. What is the situation like now?

- Are you still working with the person who made the accusation?
- What is your relationship with them like now? Has it changed?

***8. What has been the **effect** of this on you?

- Did you consider leaving the organisation or changing jobs?
- If clinical role: how you dealt with patients / colleagues?
- Work (productivity, concentration, professional reputation/status)
- Confidence
- Health
- Relationships and home life, work-life balance
- Sickness rates
- Stress

***9. How do you feel the **Trust** deals with bullying generally?

- Is the bullying management process effective and fair to all employees?
- Is there enough support in place?
- Do you think the Trust takes bullying seriously?
- Do you think the Trust deals with bullying appropriately?

***10. Do you have any **suggestions** as to how Trusts could improve how they manage workplace bullying?

11. Are you aware of the Trust's bullying **policy**?

12. Do you know where to look to find the policy?

13. Do you know what **support** is available and how to access it?

14. Did you get support or advice from elsewhere (outside the Trust)?

[GO TO CLOSE OF INTERVIEW OR ADDITIONAL QUESTIONS IF TIME REMAINING]

If interviewee has limited experience of bullying...

1. Do you have any experience of borderline bullying behaviours?

- Has someone's behaviour made you feel uncomfortable or bullied, but you decided not to report it?

What do you consider to be workplace bullying? [open question first]

- Which NAQ behaviours do you regard as bullying? [have NAQ-R ready]

2. If you were bullied, what would you do?

- Would you report it? Who to?

3. What support do you think would be helpful if you were bullied (or accused of bullying)?

4. In general, do you think the Trust deals with bullying effectively?

- What would you change/improve?

5. Are you aware of the Trust's bullying policy?

6. Do you know where to look to find the policy?

7. Do you know what support is available and how to access it?

Additional Questions

If bullied / witnessed bullying:

1. What were the reactions of the people you work with? **[CUT IF NO TIME]**

- Did they witness this behaviour?
- Did they do anything?

If yes: could you tell me about what they did?

If no: why do you think they didn't do anything?

- Do you think it affected them? If so, in what way?
- Did it affect the atmosphere at work?

2. Could you tell me about the person doing the bullying? **[CUT IF NO TIME]**

- How did (s)he treat other people at work?
- How did they act?
- Do you think their behaviour was intentional?

3. Could I ask a more general question: What do you consider to be workplace bullying?

- Behaviours (have NAQ-R ready with examples)

If accused of bullying:

1. What were the reactions of the people you work with? **[CUT IF NO TIME]**

- Did they do anything?

If yes: could you tell me about what they did?

If no: why do you think they didn't do anything?

- Do you think it affected them? If so, in what way?

2. Could you tell me about your relationship with the person who accused you of bullying?
[CUT IF NO TIME]

- Previous relationship?
- How would you describe their relationships with other people at work?

Close Interview

16. Is there anything you would like to bring up which you think I might have missed?

- Thank you very much for your time – we really appreciate you giving us your views.
- Your views will contribute to our project, which aims to improve our understanding of bullying and what Trusts can do to improve how bullying is handled.
- Please don't hesitate to get in touch with us if you have any questions about the research.
- Would you like me to tell you about support services in your Trust?

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Acknowledgements: We are grateful to Charlotte Rothwell for contributing to the design of the study. This project was funded by the North East Strategic Health Authority and the Northern Deanery in the UK. The funding organisations had no role in the study design or analysis of raw data.

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Article Citation

Thompson, N. J., Carter, M., Crampton, P., Burford, B., Illing, J., & Morrow, G. (2020). Workplace Bullying in Healthcare: A Qualitative Analysis of Bystander Experiences. *The Qualitative Report*, 25(11), 3993-4028. <https://nsuworks.nova.edu/tqr/vol25/iss11/12>
